AGED AND DISABLED WAIVER PROGRAM
MEDICAL NECESSITY EVALUATION REQUEST

Please return to
APS Healthcare, ADW Program, 100 Capitol Street, Suite 600
Charleston, WV 25301 Fax: Toll Free Fax: 866-212-5053

Please check one:____ Initial____/Reevaluation

APPLICANT/PARTICIPANT INFORMATION:

Name:_____Date of Birth____/____/____Sex_____(check one) M☐ F☐
SSN:_____ Medicaid #:_____Medicare #: _____
Physical Address: _____ City: _____State: _____Zip:_____
Mailing Address: _____City:_____ State: _____Zip: _____
Phone #: _____ County of Residence: _____

_____ _____
Signature of Applicant/Participant **Date**

LEGAL REPRESENTATIVE, GUARDIAN OR CONTACT INFORMATION: (Required if applicant/participant has Alzheimer's, dementia or a Related diagnoses)

Name: _____ Phone #: _____
Mailing address: _____ City: _____State: _____ Zip: _____
Relation to Applicant/Participant: _____
(check one):
☐Guardian ☐Committee ☐Power of Attorney ☐Medical Power of Attorney ☐Durable Power of Attorney ☐Contact

_____ _____
Signature of Legal Representative (no signature needed if contact person) **Date**

CASE MANAGEMENT AGENCY or FISCAL EMPLOYER AGENT INFORMATION: (Reevaluations Only)

Agency Name: _____ Case Manager/Resource Consultant: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ Fax #: _____

REFERRING PHYSICIAN'S INFORMATION: (This information may be shared with the applicant/participant.)
THIS INFORMATION MUST BE LEGIBLE OR THE REQUEST WILL NOT BE PROCESSED.

Name (MD, DO, PA, ANP): _____ Phone #: _____ Fax #: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Patient's Diagnoses and ICD-10 codes:
_____
_____
_____
Other Pertinent Medical Conditions: _____
_____

Does the individual have Alzheimer's, brain multi-infarct, senile dementia or a related condition: (circle one) Yes ☐ No ☐

Is the patient terminal? (circle one) Yes ☐ No ☐

_____ _____
Signature of Physician (MD, DO, PA or ANP; original required) **Date (valid for 60 days)**